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LEADING ARTICLES

MARGINAL TATTOOING AS A MEANS OF ADDING TO THE APPARENT WIDTH OF THE LIPS.*

CHARLES C. MILLER, M. D.,

CHICAGO.

THE status of featural or cosmetic surgery is such at the present day that I feel the necessity of beginning every article upon this subject with more or less of a defense of the specialty. The profession is almost as a unit in denying the specialty judging from the contemptuous indifference with which they treat the subject, but the public is by no means of that disposition, for the barometers of public opinion and desires, the newspapers, continue to lengthen their column upon the perpetuation of beauty.

The difficulties beauty editors have in filling their columns with material which has a semblance of originality is illustrated by the avidity with which they seize any scrap of information which is the least of an original nature. Recently I was astonished upon opening one of our metropolitan dailies to find that some delving beauty editor or special writer had happened upon one of my articles from the medical press, and the article was quoted almost in its entirety, and illustrated with an extravagance which no medical editor would have considered for a moment. Fortunately for my ethical standing I was mentioned only as "a distinguished surgical authority," a distinction which I might have appreciated more had it come from some other source. The reason I mention the publication with so much eclat of a simple operation, is to show that the public press is decidedly interested in this subject, and no one better judges the interests of the people than the newspaper editor.

Medical editors in a measure appreciate that the specialty will some day have a place as a specialty, for they are willing at least to give space to articles upon the subject. Many aspirants for surgical fame might better be occupied in developing their skill as featural surgeons rather than in devising and elaborating visceral mutilations, the physical discomforts of which are sometimes so great as to counterbalance psychic advantages. Every surgical field has been invaded amid much protest on the part of the profession with perhaps the exception of the cranial cavity. In his latter instance more than one surgical enthusiast has unsuspectingly entered to face disaster.

In the field of featural surgery I would recommend that the beginner work with the greatest of caution for the consequences of mischance are such as to discourage the most hardened. This was illustrated by the rapid fall in popular favor of the paraffin injections. Hundreds of surgeons have cast aside paraffin syringes in disgust and are loath to consider any featural operations as the result of their discouraging experiences with this system of prosthetis.

Tattooing is to have a definite place among the recognized operations of the featural surgeons of the future. Tattooing is something with which we are all acquainted. We have seen the effects of the practice for the purpose of adornment, and while we have questioned the taste of those who have previously submitted to this procedure, when performed so that it is indistinguishable from the natural I think it will satisfy the most esthetic, and as its effects are permanent and unchangeable, these effects are likely to remain satisfactory.

Tattooing about the margin of the lips to overcome the appearance of undue thinness of the lips requires a good deal of delicacy on the part of the surgeon to secure a tinting which will be a shade between the normal

redness of the lips and the natural color of the skin. The surgeon should not attempt to match the natural carmen red of the lips when he tattoos, but should secure an effect somewhat lighter than that of the lip so that should the patient become anemic at some future time the red line will not show incongruously.

The matter of shading is merely a matter of care, and in the first few cases the surgeon should remember that it is easier to repeat the operation and increase the amount of pigment rather than decrease it. The placing of pigment is a matter of no difficulty.

The skin is punctured or picked open with a needle. The puncturing does not extend through the skin, but merely into the true skin. After the punctures have been made the coloring is rubbed in with the point of the needle or with a slightly flattened spud. Some reaction may be expected to follow the operation, but healing is complete in a few days.

Where the lips are much inverted and show a considerable degree of inversion as the result of the habitual compression of the labial muscles it is well to evert the labial mucosa by plastic operations within the mouth and division of the orbicularis oris at the angle of the mouth is usually advisable as well.

Marked improvement may be secured by tattooing along the margin of the eyelids at the roots of the lashes, and the appearance of the eyebrows may be strikingly altered to advantage by skillful tattooing.

ACCORDING to the Journal of the Michigan State Medical Society there are in the world 250,000 physicians, half of whom are in the United States. This would make one physician to about every 620 people, or one to about every 124 families.

NUMBER OF MEDICAL STUDENTS IN AMERICAN SCHOOLS.—The total number of medical students (matriculants) in the United States for the year ending June 30, 1907, was 24,276, a decrease of 928 below 1906 and a decrease of 1,871 below 1905. Of the total number of students, 22,303 were in attendance at the regular schools, 1,039 at the homeopathic, 545 at the eclectic, 97 in the physio-medical and 292 in unclassified schools. The total number of graduates for the year ending June 30, 1907, was 4,980, a decrease of 384 below 1906, 626 below 1905, and 767 below 1904. The number of graduates this year is the lowest since 1890, when it was 4,454.

ARTERIA ILEO-COLICA IN TWENTY-FIVE SUBJECTS (PRELIMINARY NOTE).

BYRON ROBINSON,

CHICAGO.

Origin.—The arteria ileo-colica arises from the middle of the concave right side of the arteria mesenterica proximal opposite the origin of the fifth to the eighth arteriae intestinales.

Branches of the Ileo-Colic Artery.—1, ramus colicus; 2, ramus iliacus, 3, ramus ileo-coecalis dorsal; 4, ramus ileo-coecalis ventral (3 and 4 "ileo-colic arches"); 5, amus appendicularis.

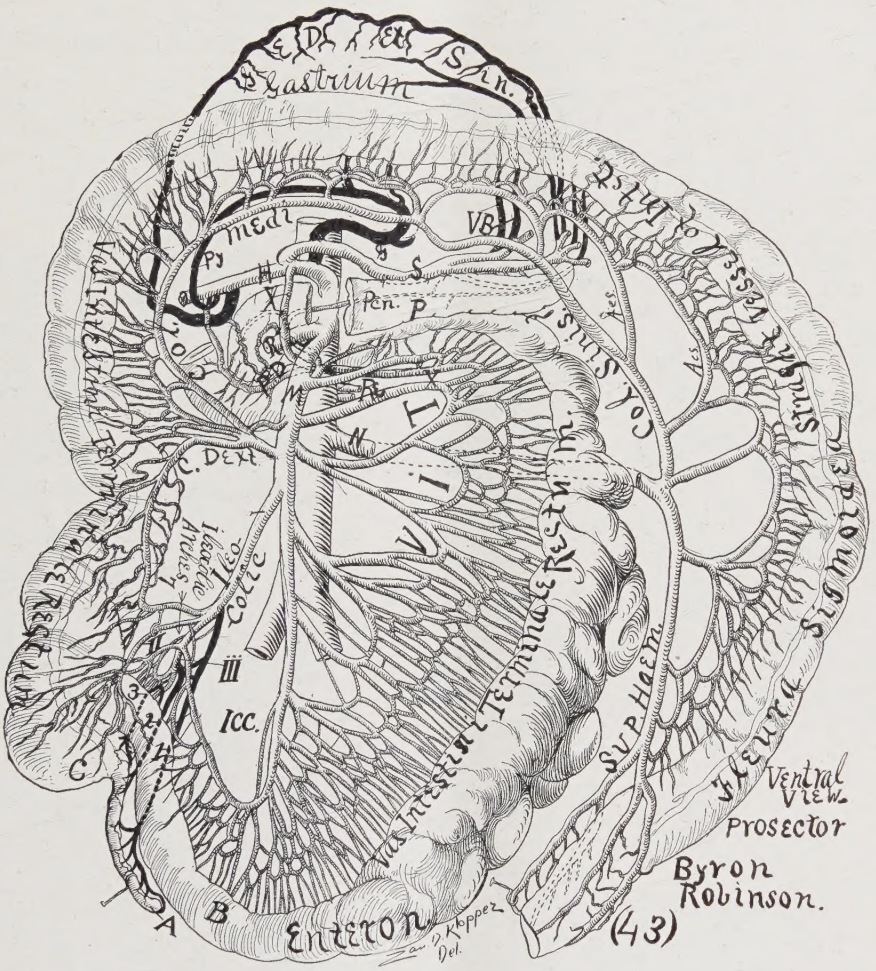
Course.—The ileo-colic artery courses obliqueward, rightward and distalward between the blades of the right mesocolon to ward the mesenteric space in the ileo-colic angle where it divides into its five branches (see division of branches). The course of the five branches of the ileo-colic artery are: The ramus colicus directs itself lateralward and proximalward between the right mesocolic blades to supply the distal right colon and anastomose with the arteria colica dextra. The ramus iliacus directs itself medianward and distalward between the mesenteric blades to supply the distal ilium and anastomose with the distal branches of the arteria mesenteric a proximal —forming the "ileo-colic circle." The arteria ileo-coecalis dorsal and ventral direct themselves obliquely rightward and distalward between the right meso-colic blades to supply the cecum, forming the "ileo-colic arches.' The ramus appendicular courses obliquely rigtward and distalward between the right mesocolic blades, dorsal to the distal ileum, and finally courses between the blades of the meso-appendix to supply the vermiform appendix. The arteria ileo-colica is enclosed in the strong fibrous mesenterii membrana propria as a bed, which is covered on the right and letf side by a single layer of peritoneum proper—the two external layers of peritoneum and mesenterii membrana propria constituting the mesentery proper.

The termination or intestinal segment supplied by the ileo-colic artery is: distal ileum, appendix, cecum, distal right colon and anastomosis with the colica dextra and proximal mesenteric.

Dimension.—The ileo-colica artery is about one-sixth of an inch in diameter and about four inches in length. The arteria ileo-colica not infrequently presents duplicity (see Fig. 43).

Topography.—The topography of the arteria ileo-colica varies within minimum limits. The ileo-colic artery is practically constant. The topography of the branches varies considerably. For example, the artery of the appendix varies from 1 to 5. The arteria ileo-coecalis dorsal and -ventral, which in combination form what I term the "ileo-coilc arches," vary from 1 to 14 arches

Clinical Significance of the Ileo-colic Artery.—The clinical signification or the applied anatomy and physiology of any structure is its association with function and disease. The ileo-colic artery is intimately associated with function and disease. The ileo-colic artery is intimately associated with the following subjects, viz: (1) It assists in forming the "ileo-colic circle."



ARTERIA ILEO-COLICA.

Fig. 43.—I dissected this specimen under 2 per cent formaline. It was vigorously and persistently injected with red lead and starch. It presents the ileo-colic artery, the ileo-colic circle (ICC), the ileo-colic arches and the vas intestini terminale rectum or straight terminal vessel of the intestine—important in surgical procedures in rder to avoid gangrene. The gastric and appendicular arteries are in black.

—averaging five arches for each individual.

The ramus colicus which anastomoses with the colica dextra varies considerable in position, origin and dimension. The topography of the ramus iliacus varies chiefly in duplication. The distal end of the ileo-colic branches anastomose with the distal end of the proximal mesenetric branches—forming the constant "ileo-colic circle."

By dissection of fifty consecutive subjects, and by searching text-books of vascular anatomy of the intestinal tract, since the days of Tideman (1781-1860), the practical founder of angieology, to the present I found that there is one constant mesenteric vascular circle, viz., the circle produced by the anastomosis of the arteria-ileo-colica and arteria mesenterica proximal. This circle,

one of the constant mesenteric arches, is located practically in the ileo-colic angle. It is a circle of considerable dimension resembling the concentric gastro-hepatic circle. It is lesser in dimension than that of Willis. This circle is associated with the distal ileum and cecum, right psoas, common iliac, with the atrophic mesenteric apertures in the ileo-colic angle, the ureter and the dangerous, treacherous appendix, in fact the right circumference of the "ileo-colic circle" not infrequently gives origin to the appendicular artery which fact alone dignifies the "ileo-colic circle" into clinical significance.

The ileo-colic circle may present a large fibrous mesenteric pouch which appears to be supplied by minimum blood vessels. It could atrophy and be the site of hernia (mesenteric). The ileo-colic circle accounts for the mesenteric atrophy found in the ileo-colic angle. The ileo-colic circle may be divided by arteries extending across its plane. (2) It is associated with the "ileo-colic arches."

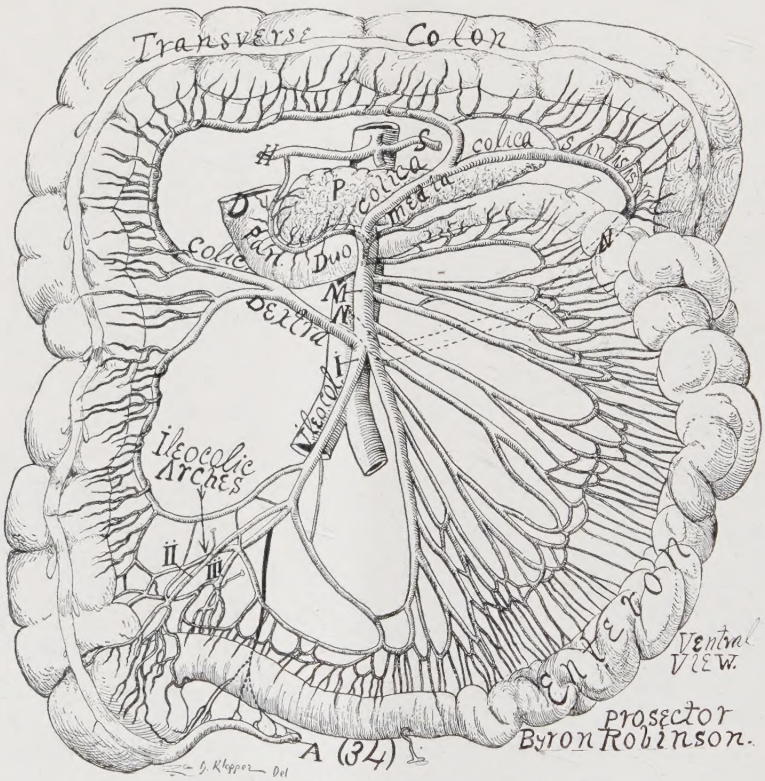
In the region of the ileo-colic angle, i.e., at the junction of the ileum and colon I found at the termination of the ileo-colic artery numerous strong arches, compact vascular anastomoses. The "ileo-colic arches" average five in number for each individual.

At present the ileo-colic arches are in direct relation to the cecum. I claim that these "'ileo-colic arches" are remnants of a primordial vascular landmark, a rest of some ancient vast anatomic structure—a maximum herbivorous stomach, now the atrophying, fading, appendix.

(3) The ileo-colic artery is associated with the origin of the artery of the appendix.

The right circumference originates, in the vast majority of subjects the arteria appendicularis which is one of the significant arteries of the body. The appendicular artery varies from 1 to 5, averaging for each individual 1.75 per cent.

(4) The study of the "ileo-colic circle" is for the purpose of controlling its blood stream. Not infrequently the ileo-colic circle is afflicted with atrophy of its mesentery. The blood supply in the central portion of its plane is deficient, inducing atrophy,



ARTERIA ILEO-COLICA.

Fig. 34.—I dissected this specimen subsequent to vigorous injection under formaline. The ileo-colic artery lies on the arteria iliaca communis dextra. In Fig. 34 the ileo-colic circle is divided by a large artery. The ileo-colic artery terminates in the ileo-colic arches. Observe not only the ileo-colic circle and the ileo-colic arches, but also the vas intestini terminale rectum or straight terminal vessel of the intestine, which presents ample length to be ligated or clamped in intestinal surgery without molesting the mesenteric arches, especially in the region of the arteria colica transversa—the region of Riolan's arch or Haller's arch.

apertures in the mesentery of the ileo-colic region, which may serve as strangulating hernial apertures.

ORTHOPEDIC SURGERY IN GENERAL PRACTICE.*

JAS. W. COKENOWER, M. D.

DES MOINES, IA.

THE field of the general practitioner is the Mecca for all ethical, as well as some that are not ethical, specialists, because the general practitioner's ever watchful eye, close observation and scrutinizing diagnosing makes it possible for him to see the need of special work in his practice, from which

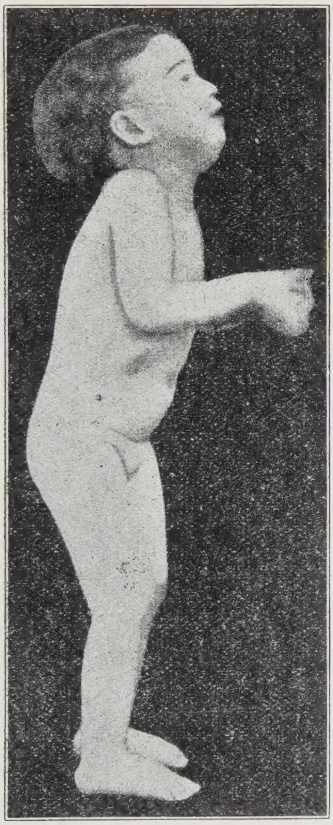


Fig. 1.

all such work must come, and call to his assistance any kind of specialist needed, and in time to prevent what might have other wise been disastrous to his patient. The writer spent several years in general practice, and from that experience, as well as his specializing in orthopedic surgery, he wishes to present a few facts about deformities in general, and especially those that shorten life and destroy the natural contour of the body.

IMPORTANCE.

The etiology and pathology of tubercular bones, especially the spine, is of much importance, but time forbids anything further than to give the general diagnosis and treat-

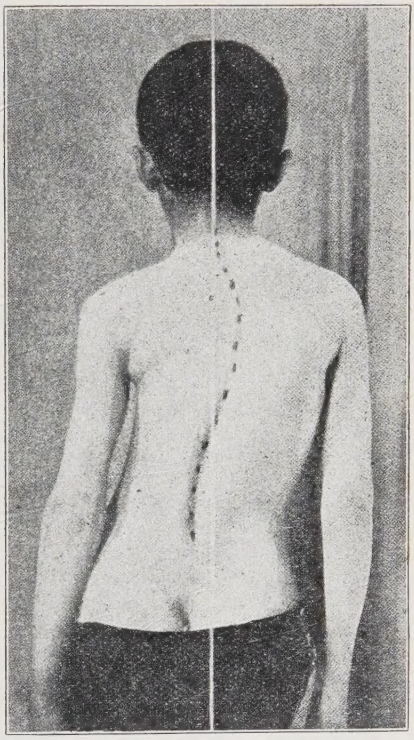


Fig. 2.

ment of the several subjects to be considered.

The importance to us and anxiety of our parents when we were children, that we should have a stately form, dignified appearance and perfect mental and physical development, is no less true now than it was then, and the physician who neglects to observe the little things about the children of his clientage that detract from or prevent the normal development, deformities or erect contour of the children included in his practice, has neglected one of the best means of obtaining the good will and confidence of his patrons.

SPINAL CURVATURES.

The symptoms of spinal curvatures, prior to deformity, are often obscure and diagnostic mistakes are often made, but should not be, when the disease has advanced far enough to produce a deformity, no matter how small,

*Read before the Medical Society of the Missouri Valley at Council Bluffs, Ia., September 6, 1907.

although the cause of the deformity may have existed some time, and the important point is to diagnose the case before the deformity occurs.

The nerves that make their exit from the spinal canal, opposite the seat of disease, become involved and manifest same at their distal extremities, hence, if the trouble ex-

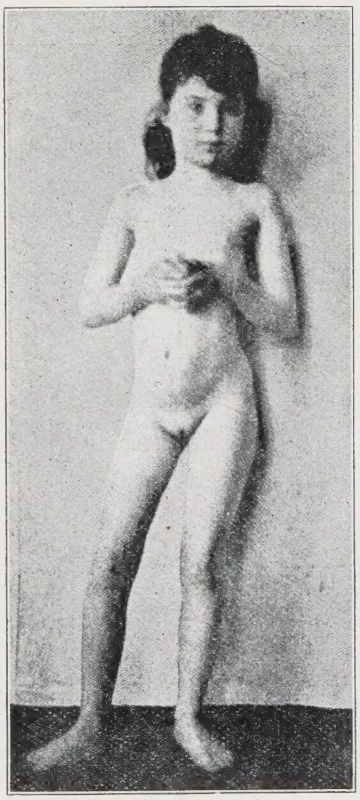


Fig. 3.

ists in the cervical region, the patient may have difficulty in swallowing, constricting or choking sensation, and in dorsal region, pain in thorax and cough, and in lumbar region, constipation, flatulency, pain and frequent urination. When such symptoms exist and cannot be explained by some etiological factor, go back to the point where the nerves distributed to these regions make their exit from the spinal canal and examine the vertebrae.

The reflex and muscular contractions change appearance in action, or patient who will walk with guarded step, elevated chin (Fig. 1, Whitman), rigid spine, squat and climb limbs in picking up coins, easily fatigued, prominent abdomen (Pott's disease) and prominent hip on one side and elevated capsula on other (Fig. 2, Lovett) lateral curvature, are among the many things observed in early diagnosing spinal disease and deformities, which more than all other deformities shorten life by interfering with the normal functions of the organs of the thoracic and abdominal cavities.

The treatment is quite satisfactory and consists in constitutional and mechanical, of the latter, rest, immobilization, ambulatory, if possible, and extension are of special importance; and when used early should prevent any deformity and when not early, should prevent the deformity from increasing.

HIP JOINT DISEASE.

The early diagnosing in hip joint disease is the predominating factor on which depends the beginning of the end that enables us to handle such cases successfully.

The etiology and pathology of tubercular hip joint disease does not differ materially from that of tubercular spine, and while very important, is not as much so, as to know what to do to overcome it and prevent a deformity. The diagnosis is not difficult, for the preliminary symptoms, of favoring the leg, guarded limping gait, limited mo-

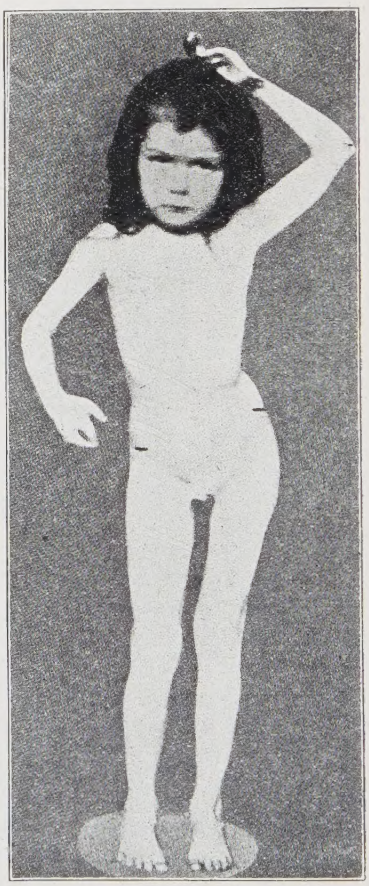


Fig. 4.

tion, flexed thigh and leg, easily fatigued, night cries, pain, although this is not severe in the hip, but is on the inner side of the knee and it is this symptom that is often misleading, stiffness, distortion, change of contour and atrophy. Since we are not always consulted at the beginning of the disease, it is necessary to know the stage and progress it has made in order to give timely relief, so for convenience, will divide the dis-

Fig. 5.—Rubber Compressor for Knee and Ankle-joint.

ease into three stages, to wit: the first is the onset or beginning of the inflammatory stage and the symptoms are night cries, pain in knee and limping gait; second is a further advancement of the inflammation, causing exudation and breaking down of intra-articular surfaces, often involving the bony structures in the acetabulum, and the symptoms are increased pain, apparent lengthening of limb (Fig. 3, Lovett) eversion of toes abduction and outward rotation of thigh and increased mobility of limb, and third stage, diminished pain, due to rupture of capsular ligament, shortening of limb inversion of toes (Fig 4, Whitman) and adduction and inward rotation of thigh.

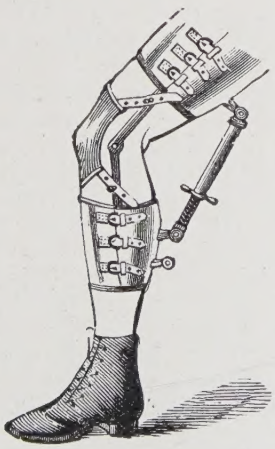


Fig. 6.

With this history before us, we should be able to supply well-timed treatment, and among the principal ones would be rest, immobilization, extension and counter-exten-

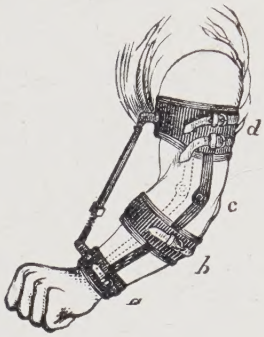


Fig. 7.

sion, not in the line of the normal axis of the body, but of the deformity and lateral traction, which will better serve to take the pressure from the intra-articular membranes, which is not wholly for the purpose of remedying existing deformity, but to retard and prohibit, if possible, the destruction of tissue, to prevent the deformity from increasing.

The idea that convalescence should be interfered with, simply to prevent deformity

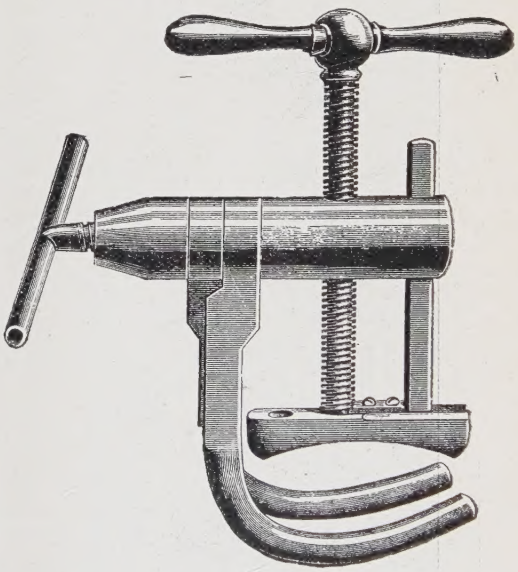


Fig. 8.

is not feasible and all things being equal, and recovery can be accomplished without deformity, it is much more preferable, but I believe if we were to give less attention to the deformity, while ravages of the disease are in action and simply assist Nature in her efforts, we should get better results.

When internal medication, augmented with external treatment fails, then operative measures are indicated and should not stop short of removing all necrosis and caries, even if that include osteotomy and exsection.

GENERAL JOINT DISEASE.

Chronic joint disease, especially knee and ankle in children, nine cases out of ten, means tubercular, while acute joint disease means non-tubercular about nine out of ten, and in either case, the earlier the correct diagnosis is made the more efficient the treatment and less deformity.

Differential diagnosis is the best plan to pursue and neuro-deformities and rheumatism play a conspicuous part and are often misleading.

Impaired functions of joints, limited motion, limping gait, when in lower extremities, pain on motion, night cries, pain on point of pressure, swelling, to which add a subjective history, and we have at our command the principal factors necessary to make a correct and easy diagnosis, in any kind of joint disease.

The tuberculin test has not proven what is claimed for it, in my experience, although of some importance from a negative standpoint, is of no practical value in establishing a correct diagnosis. The X-ray is a good

Fig. 9.

Fig. 10.

diagnostic assistant in adults, but comparatively useless in children because of the non-development of the epiphesis of the ends of the long bones, which is usually the location of the beginning of all joint disease, not malignant, septic or traumatic.

The treatment like that of many of the diseases, includes rest, position, immoblization, extension and couter-extension, this should be made at the line of the deformity and not the line of the normal axis of the body; after this is done, local cold or hot compression, by means of flat sponges and roller bandages around the joint, or what is better, the rubber joint compressor (Fig. 5) which can be made to fit any joint. When possible, in knee, ankle or elbow, control the arterial supply of blood to the parts by means of compression, in such a manner as to hinder the invasion of the phagocytes on the leucocytes, and thus diminish the inflammation by partial arterial starvation.

Fig. 11.—Talipes Equinus.

This, in brief, is a line of treatment that usually succeeds in overcoming the acute or inflammatory stage, when taken in time, and assisted with whatever constitutional treatment the case demands. However, there are many cases of joint disease that have passed the acute stage before any treatment has been given, because of the assiduous characteristics of the disease, which may have existed for months, unsuspected, when sometimes after a fall, blow or accident, it will reveal what has already existed, and even a small injury will often do more

Fig. 12.—Talipes Calcaneous.

harm than a large one. In many cases there is no history, if any, not good, of injury and the disease follows measles, whooping-cough, scarlet fever, marasmus, dentition, or cholera infantum. In such cases the treatment will necessarily be governed by the cause and existing stage of the disease, no matter what that is, and if passed to the stage of breaking down, the continuity of osseous and soft tissue, curetting, drainage, exsection or whatever else is indicated, and if so much of the intra-articular tissue has been destroyed and anchylosis is inevitable, the limb should not be allowed to anchylose in any position except that in which the limb will be the most useful, as in the ankle, the foot should be maintained at a right angle, knee and hip, in the axis of the body, while

Fig. 13.—Talipes Varus.

the elbow should be held at a right angle, being the position most useful.

Mechanical appliances (Figs. 6 and 7) can be used to a good advantage in overcoming anchylosed deformities by stretching contracted muscles and tendons.

KNOCK-KNEES AND BOW-LEGS.

The modern treatment for genu-varum or bow-legs and genu-valgum or knock-knee, is no longer with braces, although braces properly worn, which they seldom are, will give satisfaction in mild cases, but a majority of them we do not see until the deformity becomes well marked, because the parents have been advised by the "knowing ones" that their child would outgrow the deformity.

Fig. 14.—Talipes Valgus

Manual osteoclasis, when the bones are soft, has a place in the operative treatment, but even then does not have any advantage over the osteoclast (Fig. 8) and lacks precision.

Osteotomy is the most popular operation for the correction of severe rachitic deformi-

ties of the thigh, legs and arms, but has many disadvantages when compared with rapid osteoclasis, because the open incision makes way for infection, requires more preparation, time and gives pain, but the most serious objection in osteotomy is the delayed union as compared with union after osteoclasis or green-stick fracture.

This is due, no doubt, to severing the continuity of the bone shaft and carrying soft tissue into the open space.

I am aware there will be objections to osteoclasis, contending there is great danger to soft parts, blood vessels, nerves, etc., and in reply to this will say that no doctor has practiced medicine long, who has not had a case of fracture of some kind, due to accident or trauatism, which was nothing more or less than the osteoclasis, and arms of the force were not padded either; neither was the power made to order and carefully guarded, but he immobilized the bones in apposition, the same as is done in osteoclasis.

The compression of the soft parts is of such transitory nature in rapid osteoclasis that the tissues rebound instantly into their normal condition, the circulation is immediately resumed and no bad or even unsatisfactory effects are ever observed and does not require but a few seconds, and putting on the plaster cast but a few minutes, hence, the danger and nausea from the anesthetic is obviated, and as there are no abrasions of the skin or bruising of soft parts, the infection and abscess are never seen and union takes place promptly in four to eight weeks (Figs. 9 and 10), depending upon the age of the child. I think there is a field of usefulness for the osteoclast in corecting the deformities of the long bones, breaking up fibrous and bone anchylosis, stretching muscles, tendons and nerves because the work of the osteoclast can be done with so much mathematical precision which cannot be obtained otherwise that the method commends itself to any physician or surgeon who may have an opportunity to try its merits.

CLUB FOOT.

The deformities of the feet are congenital or acquired, and the latter from burns, traumatism or infantile paralysis which may be due to dentition, scarlet fever, diphtheria, spinal meningitis, typhoid fever, or to some injury to the nerve centers, and usually affects only one extremity, as an armor leg, yet often does both, and so soon as the cause begins to disappear and the effusion taken up by absorption and pressure lessens, then sensation and motion begins to return and certain muscles become vitalized sooner than others, the flexors, being stronger, have the advantage and divert the limb and foot in the line of contraction, producing the deformity, which is augmented by the weight of the child. So soon as it begins to walk, and unless corrected promptly, the deformity will increase.

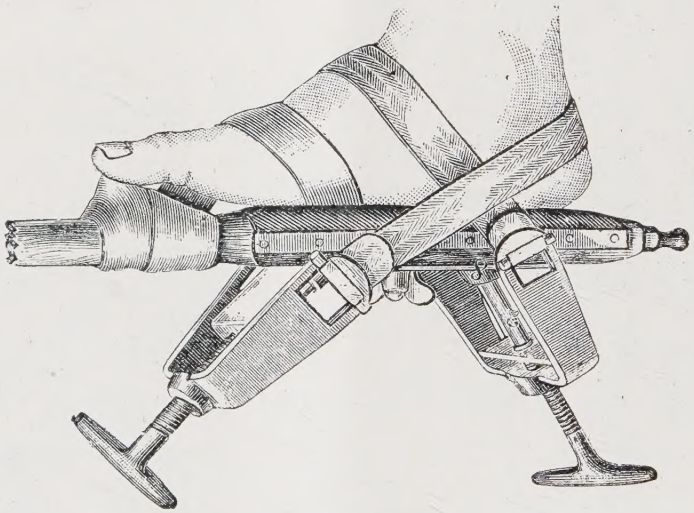


Fig. 15.

Congenital club-foot is the one our attention is called to most frequently and the treatment has been, on the theory that the pathological condition was a spastic muscular contraction.

For instance, when there is a muscular anterior extension and contraction of the gastrocnemius, soleus and plantaris, or shortening of the tendo-achilles, we have equinos (Fig 11.) and a flexion or contraction of the

anterior muscles of the leg will produce a deformity exactly opposite, called calcaneous (Fig 12), adduction of the tibial muscles will produce varus (Fig 13.,) and abduction of the peroneals and extensor longus digitorum will produce valgus (Fig. 14). Realizing then, that we have to contend with

Fig. 16.

these deformities, there are two things to be considered, first, when is the best time to commence; and second, what should be done.

There are many kinds of treatments, constitutional, mechanical, subcutaneous myotomy and tenotomy, open incision, osteotomy and osteoclasis Each of these have their place in properly selected cases; for instance, if the cause be the nervous system, constitutional treatment and mechanical applicances properly adjusted, so as to overcome the spasm of muscles and support the opposing ones may suffice.

Unfortunately, a majority of cases do not come under this head, but have been delayed until more radical means are demanded, many of such cases can be corrected with the club-foot osteoclast (Fig.15,) which the operator can adjust to suit the case and apply any amount of force desired, breaking the bones, and stretching the muscles, ligaments and tendons, and then by putting the foot into a plaster of paris cast, often gets very satisfactory results, but a majority of the cases demand orthopedic surgery, and when this is the case, the surgeon should not cease operating until the foot is super-corrected, no matter how much cutting is needed or force demanded, and then results will be satisfactory (Figs. 16 and 17,) otherwise relapse may be expected because the operator concluded his work before the foot was over-corrected.

When the foot has been over-corrected and proper mechanical appliances used (Fig. 18) relapses do not occur. The advantages of such an operation are, first, cutting parts as they offer resistance in their respective order, prevents cutting unnecessary tissue; second,

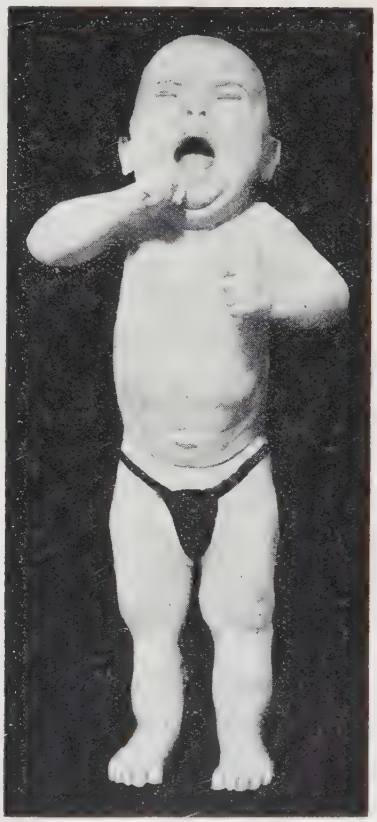


Fig. 17.

after all resisting soft parts have been divided, it is easy to learn the amount, if any, of bone deformity which can easily be remedied with the osteoclast or chisel, and last, it makes the operator master of the situation, and results will be satisfactory.

CONCLUSION.

1. All deformities of the spine can be relieved, if treatment begins early, or as soon as any deformity exists, and those without bone deviations are simple and amenable to successful correction and those with osseous change, even in children can be improved.

2. The law of growth and development of osseous, as well as soft tissue, is fully demonstrated in the abnormalities, distortious deformities and actual and permanent normal functional disturbances, when the equilibrium of the normal axis of the body

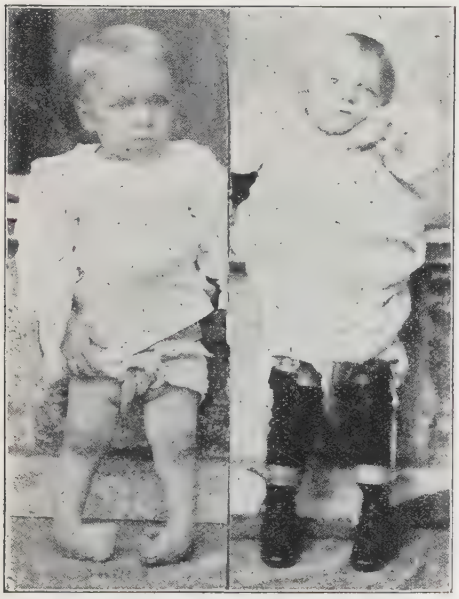


Fig. 18.

has been destroyed, no matter whether it be done by torticollis, spine, hip, knock-knee bow-legs, short leg, club-foot or any other cause, the results are the same according to the severity.

3. The medicinal and mechanical treatment should be augmented with hygiene, exercise, gymnastics and all other properly guarded means to develop the body, build up muscle and improve the general health when less deformities will exist and longevity of the children under our care be increased.

THE Whitney Anti-Cocaine Bill, which has become a law in New York State, provides that cocaine cannot be sold by jobbers save to a registered physician, druggist or dentist. The dealer must keep a record of the date of sale, name and address of purchaser.

SECRET COMMISSIONS.

E. S. MCKEE, M. D.

CINCINNATI, O.

COMMISSIONS on prescriptions creep into notice once in a while. We learn all the way from Delhi, India, through Practical Medicine of that place, that a Wisconsin judge took the proper view of this practice, which though rare, is doubtless done to a small extent. The ruling of the judge was that "any contract made between physician and druggist, whereby the former is to receive a commission from the latter for sending prescriptions to him is illegal and against public policy." A suspicion soon accrues to the physician who unduly urges his patients to take his prescriptions to one particular pharmacist that he is being bribed to do so by a commission by the pharmacist It has been rare that this has occurred in Cincinnati, but there have been a few such cases, and if we are to believe a widespread rumor there is one very flagrant case of this kind on hands now. An ophthalmologist who insists on his patients buying their glasses at a particular store lays himself open to the same suspicion. There have been a very few cases of this kind in Cincinnati. It is true that a physician should direct his patients to take their prescriptions to the best pharmacist in his neighborhood, and the oculist should do the same with his prescriptions for glasses, but in large cities there are so many good dealers and pharmacists that limitations are unjust and unwise, and the good of the patient is not thereby served. Another scheme for biphlebotomy is to prescribe under a number or name or cipher understood only by a certain druggist or dealer, with whom the physician is in collusion. The patient is thus obliged, no difference how disagreeable or difficult or distant to go to this particular pharmacist or dealer, under the impression that none other is capable or able to put it up properly, thus working an insulting injustice to other members of his calling. Sanitaria, mineral springs, proprietary medicine companies and such frequently offer physicians shares of stock on the business sent them as an inducement to the subscriber to take a more personal interest in furthering the sale of the goods.

Legislation against graft has been remarkably active in this country as well as in England and Australia of late. The Prevention of Corruption Act which has been recently passed by the British Parliament, the giving and receiving of secret commissions must have been assumed to be a much more com-

mon practice than is generally admitted. For example, under this act: "Medical practitioners must not receive commissions from trades people in return for recommending their wares; or from a dentist for recommending patients; nor are they allowed to pay commissons to hotel proprietors, lodging house keepers, monthly nurses, midwives or others for introducing cases. A consultant must not share his fee with the medical attendant. Commissions may be paid to agencies for introducing resident patients; but no medical practitioner may be able to receive a commission for recommending a patient to a colleague, or from hotels, boarding houses, lunatic asylums, or sanitoria, or for any service where his whole duty is to his patient, from whom alone he should accept remuneration." We much prefer to believe that these provisions are more prospective than retrospective. We would be sorry to think that such practices were common enough to demand legislative action in our own country. In any case they assume such a degree of degradation of a noble profession as is hard to conceive of. It is even claimed by those in position to be well advised that certain hospitals offer inducements of bringing in patients, in the form of tips, lunches, solid and liquid, for police and patrol offices and other runners. The hospital it is true is the greatest grafter the doctor has to contend with when it comes to emergency or accident cases. It is difficult for the doctor to keep his own patients when injured from being hauled off to the hospital right under his nose by energetic squads of patrolmen. It has even happened in Cincinnati that they have endeavored to capture members of doctors own families when injured and haul them off to the hospital nolens volens, and only the most energetic protests prevented.

San Francioso suffered for the sin of commissions on prescriptions as well as many others at the great earthquake. The pharmaceutical press contained a statement of the bad conditions there which thinking overdrawn was sent to one of the prominent phyiscians in San Francisco with a query as to its truth. His reply was that there was only too much truth in it. He said that the doctors of San Francisco had it in mind to fight the custom some day, but were to busy now with the patent medicine fraud to take up further conflict.

The statement was to the effect that some years ago a drug store was started in San Francisco, but unfortunately lost money from the start. After a time the proprietor packed up his stock, moved to New York City, and now has one of the most successful drug stores in the Eastern metropolis. Why was the drug store such a success in New York after proving such a failure in San Francisco?

Here is the secret of the incident mentioned. The pharmacist whose business venture proved so unsuccessful was compelled to move from San Francisco because he refused to pay tribute to physicians for the privilege of filling their prescriptions. According to our authority on the matter there was only one drug store in San Francisco which does not pay a percentage to some physician for every prescription filled.

Tribute is not only laid upon the pharmacist, but we are told that even the trained nurse must turn over to the physician the half of her first week's salary in each case, in order to have her name placed on his list of eligibles, even a divy was expected from the undertaker, it is said if medical services proved unavailing. Comment on the state of morals in the medical and pharmaceutical profession of San Francisco is entirely unnecessary.

There is no doubt but that any contract between physician and druggist or other trades people whereby a commission is given or asked is illegal and against public policy. If a physician sends all his prescriptions to a neighboring drug store and gets, say 15, 20, or 25 per cent on them he will in all probability prescribe more often than is necessary, in greater dilutions and in doses of larger bulk. It is easy for the physician to make his prescription business four or eight times as profitable to the druggist as usual. Take for instance Fowler's solution of arsenic, which costs wholesale about 30 cents a pint. Prescribe one ounce to go nicely in the vest pocket and direct three drops three times a day. It will last nearly two months. Dilute this with water till the dose is a tablespoonful and an ounce bottle would hold two doses, a four ounce bottle would not last three days. Note the difference in the cost to the patient if they took it a month or two.

Russell Sage Institute of Pathology. —Three hundred thousand dollars has been given by Mrs. Russell Sage to the New York City Hospital and the City Home on Blackwell's Island. The purpose of this gift is for the endowment of the Russell Sage Institute of Pathology, which will act as pathologist to the hospital and the home. It is expected by the venerable donor that special attention will be devoted to research work in the diseases affecting the aged. The organization is to be made according to the plans and under the direction of Drs. E. G. and T. C. Janeway.

THE MEDICAL FORTNIGHTLY

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EDITORIAL

Diet in Diabetes Mellitus.

THERE is no one disease where we are more at a loss therapeutically than when handling diabetes. Our lack of therapeutic certainty has led us into an exaggerated emphasis of diet. Diet is unquestionably the important matter in handling these cases until we shall have more definite knowledge of the inwardness of diabetes than has yet been developed, but "diet" does not necessarily mean so rigorous an elimination of foods which the patient craves as to create a distress more harmful in its effects than moderate indulgence would have been. More and more frequently we are hearing prominent clinicians urge some relaxation in restriction, and personal experience convinces us of its wisdom. The average published diet list for this disease is almost an impossibility except in specially equipped hospitals, and patients soon declare it an abbomination. No set diet can be arbitrarily set down for each and all cases, each patient should be studied and in so far as it can be determined that a food is not doing harm it should be temporarily allowed. In a recent excellent article on the therapy of diabetes by Dieulafoy (N. Y. Medical Journal) the author outlines diet and treatment along rational lines. He objects to the immediate and absolute exclusion of all starches and sugars, because of the danger of rapid emaciation and of tubercular infection which always threatens in diabetic patients. Desserts, pastry, and preserves must be abstained from. The patient may have eggs, fish without sauce, broiled or roasted meats, herbaceous vegetables and gluten bread. Occasionally he may have potatoes or peas or similar farinaceous vegetables. He may sometimes substitute toast or crust for the gluten bread. Beer and milk are permitted, and also coffee and tea, with saccharin as a sweetener instead of sugar. The regimen should be very hygienic; bath, frictions, douches and massages are indicated. The skin should be stimulated, but not irritated. Exercise is important to hasten the destruction of muscle sugar; to this end walking and gymnastics are recommended. Profuse sweating and fatigue are to be avoided—for overexertion may induce a diabetic coma. Dieuafoy uses for drugs antipyrine, arsenica and alkalies, in the following manner: For one week, 5 grains of antipyrine and 3 of sodium bicarbonate in a cachet after each meal. During the following week for these cachets is substituted a tablespoonful of a solution made up of 1-8 grain of sodium arsenite in distilled water, taken after each meal. These two remedies are thus alternated for several months. At the same time alkaline waters are taken with or without wine (not sweet) at meals; chalybeate waters may be taken in appropriate cases.

Formic Acid in Diphtheria.

SINCE the general acceptance of the antitoxin for diphtheria the American profession has shown, little interest in any other therapy for that disease. That the antitoxin treatment is without question the treatment par excellence is now universally granted, but there are many occasions when it is not available, and an occasional case where personal idiosyncrasy hinder its use; such cases are sufficiently frequent to make further research distinctly in order. We do not remember having heard anything new in the therapy of diphtheria in several years until recently. A clipping from the Edinburgh Medical Journal was recently brought to our attention, in which Drs. Ker and Croom detail their results with formic acid in clinical experience with the disease. Over 400 cases were treated in the Edinburgh City Hospital during 1906, and the results are described as encouraging and warranting a further trial of the remedy. The acid was administered as 25% solution, in doses of 5 to 20 minims in water every four hours, the dose being graduated according to the severity of the case rather than the age of the patient. The effects were not noticeable until 48 hours after the first administration. After that time the pulse became less irregular, general nutrition was improved, and a most conspicuous effect was the improvement in the patient's color. The drug was well tolerated in all cases. The diuretic effect ascribed to formic acid was not confirmed. Reduction of fatality from cardiac failure was slight, but a great decrease

was observed in the paralytic symptoms, and albuminuria was materially reduced. The authors propose in future to administer formic acid to alternate patients, so as more accurately to observe its effects as compared with cases treated without it, and their further obsrevations will be looked for with interest.

Whether the formic acid was used in conjunction with other treatment and its degree of efficiency under various attendant circumstances we are not informed, but it is safe to say that the American profession will eagerly await further developments.

Water.

One of the surprising things which every physician has to meet is the aversion of the average patient to drinking water. Water is good to bathe in, but not to drink! This is especially true of women; it is nothing unusual to meet women who drink no water in its native form, depending entirely on tea and other beverages of the kind to supply the demand of the system for water. Physiologists tell us that the normal man should eliminate from two and one-half to three pints of water daily as urine; water eliminated through other channels can only be estimated; but suppose you insist on your patients drinking a total of three pints of water daily you will not have exceeded the demand, but you will meet with rebellion except in critical cases. Would patients drink water freely many benefits would result; there would be less habitual constipation, fewer headaches and nervous breakdowns. Water in abundance is essential to the smooth and normal working of the kidneys and urinary tract, uric acid conditions might be avoided by habitual water drinking. Pure water in the same quantity is quite as effective as are alkaline waters for many conditions, but it is necessary for the patient to believe the water is medicated before he can be prevailed upon to drink!

Three to four pints a day! It is a lot to drink, but if done habitually it will soon cease to be a burden and will establish itself as a necessity.

Get rid of the idea that dollars make success. It's just the reverse. Success makes dollars.

The St. Louis Medical Society is in the throes of enacting new by-laws. The document promises to be, when complete, all that could be desired in the way of completeness and serviceability.

MEDICAL PROGRESS

Comprising the Regular Contributions of the Fortnightly Department Staff.

INTERNAL MEDICINE.

O. E. LADEMANN, M. D.

On the Mechanism of Urine Formation.—Sollmann (Jour. A. M. A., August 31, 1907) summarizes his article, which embraces an extensive review of the subject, as follows: 1. excretion through the glomeruli and tubules. The modifications of Nussbaum's experiment prove that in frogs' kidneys all the normal urinary constituents can be excreted vicariously by either the glomeruli or tubules, but the elimination of water and probably of most of the ordinary constituents occurs normally only by the glomeruli, and only under unusual conditions by the tubules. Certain pigments, on the other hand, are excreted exclusively by the tubular epithelium. Attempts to separate the functions of the glomeruli and tubules in mammals has not thus far led to decisive results. It is probable, but not proved, that the same conditions prevail as in frogs. There is no conclusive evidence that urea is secreted differently from the salts. 2. Secretion or reabsorption by the tubular epithelium. As stated, the tubular epithelium can secrete all the urinary constituents in the frog. It is highly probable that it secretes pigments in mammals. It is proven that it secretes sugar under the influence of phlorodizin. There can be no doubt, therefore, that it is capable of secreting some substances, but there is no definite evidence as to whether any of the normal constituents are normally secreted by this epithelium. Reabsorption under normal conditions is neither proved or disproved; however, its acceptance, furnishes the clearest explanation of many phenomena. If it exists it must be selective, discriminating between the different constituents and varying with conditions. 3. Filtration in the Kidney.—Filtration through the glomeruli is physically possible, because it occurs in dead kidneys. The influence of saline diuretics, of changes of circulation, etc., on the urine flow corresponds closely in the living and dead kidneys. This indicates that infiltration is probably an important factor in the formation of urine, but there is no direct proof. The composition of the urine can not be explained by filtration. 4. Secretion by the Glomeruli.—It is very probable, but not proved, that glomular urine may, at times, have a much lower concentration than the plasma. The formation of such a fluid

would probably require a force exceeding the available filtration pressure—in other words, it would constitute a secretory process. 5. The Concentration of the Urine.—It is very probable, though not proved, that the urine ordinarily becomes more concentrated as it passes through the tubules. At all events the formation of a urine of greater connectration than the plasma requires an unknown force, whether secretory or absorbing, which must be classed as vital. 6. Regulation of the Urine.—There is no satisfactory explanation of the adaptation of the urine to the needs of the body, none of the proposed theories resting on conclusive proof. 7. The Action of Diuretics.—There is no binding evidence as to the mechanism of any of the diuretics, but it is still highly probable that salts act physically and mainly on the glomeruli, and that phlorohizin act on the tubules. The diuretic action of water, urea and caffein are even more obscure.

The Importance of Ice in the Production of Typhoid Fever.—Park, (Jour,. A. M. A., August 31, 1907) says the danger from the use of ice produced from polluted water is always much less than the use of the water itself. Every week that the ice is stored the danger becomes less, so that at four weeks it has become as much purified from typhoid bacilli as if subjected to sand infiltration. At the end of four months the danger becomes almost neglible, and at the end of six months quite so.

Study on Opsonins.—Moss (Bull. of Johns Hopkins Hospital, June, 1907) holds that no high degree of opsonic immunity such as is possible in antitoxic and bacterial immunity, can be produced in rabbits by ordinary inoculation procedures with staphylococcus aureus. None of the present methods of estimating the opsonic content of the blood seems sufficiently accurate to be of practical value. It seems important that further effort should be expended in finding a reliable technic for clinical purposes rather than in continuing to pile up statistics which are so inaccurate as to be misleading.

Studies on Specificity of Opsonins in Normal and Immune Serum.—Russell (Bull. Johns Hopkins Hospital, June 1, 1907) concludes the following remarks from experiments which have been repeated a number of times: 1. Following injections of bacterial vaccines, the increase of opsonins is probably due to the formation of immune opsonins which reach specifically. 2. In saturation experiments with normal or common opsonins, and these are not specific, since they can be removed by saturation with any one of a considerable number of bodies. 3. In saturation experiments with immune sera we have both the immune and the common opsonin present; the former is quite specific, while the alter is not. 4. B. pyocayenus is susceptible to spontaneous phagocytosis.

The Diagnosis of Anemia.—Cabot (Jour A. M. A., August 24, 1907) classifies the types of anemia into (1) chlorosis, (2) pernicious anemia, (3) secondary anemia, in cluding, (a) parasitic types, (b) other types, (4) myelophthisis anemia, (5) aplastic anemia. He briefly describes these various forms with the following summary and conclusions: 1. In the diagnosis of anemia it is essential to take account of all the facts in the case. The etiologic factors and the date of general physical diagnosis data are as important as the hematologic findings. Especially is this true in types of anema known as secondary. 2. There are but two important types of anemia, if we are to distinguish it by blood examination alone. To the first type (the small cell type) belongs the anemias secondary to hemorrhage, malaria, nephritis and other diseases which lead to increased destruction of red blood corpuscles. So far as the blood picture is concerned, chlorosis is identical with the types just mentioned. It is distinguished wholly by the absence of etiologic factors and by the age and sex of the patient. 3. Pernicious anemia usually, but not invariably, can be recognized by the blood picture alone. If the data of blood examination are combined with those obtained by a careful history and physical examination the diagnosis is one of the clearest and surest in medicine. The most important single fact in the blood examination is the great reduction in red corpuscles, with a relative in crease in the amount of hemoglobin per corpuscle (large celltype anemia). 4. The parasitic anemias are not always to be recognized by blood examination, but present no difficulties of diagnosis if the eggs of the responsible parasitic are sought. Myelophthisic anemia is easily recognized by the evidences of its course and offers no difficulites in diagnosis.

A Simple Proof of the Cessation of Respiration.—Pitzman (Jour. A. M. A., Sept. 7, 1907) suggests a more simple and reliable test than the mirror test. The mouth is closed by the hand and the anterior nares of both sides are filled with fine soapsuds. If respiration has ceased there is absolutely no movement of the bubble. As it is evident a patient cannot live without breathing, this test continued for a few minutes is an absolute proof of death.

OTOLOGY.

ALBERT F. KOETTER, M. D.

The Use of the Rontgen Rays in Rhinology.—(Compilation by Dr. M. Wassermann, Munsch., Internationales Centralblatt fuer Ohrenheilkunde.)—It is due to Scheier that the importance of transillumination and photography by means of the Roentgen rays was proven as early as 1896. He succeeded in demonstrating clearly, in a profile picture the frontal sinus, an advancement of great importance as up to that time no method was known by which the presence or absence of a frontal sinus could be demonstrated. He also advocated the Roentgen pictures for control of probing the frontal sinus, as we can easily satisfy ourselves, from the picture, when the sinus has been reached by the probe. Scheier has also proven differences in shadow pictures on both sides of antrum of Highmore by sideward transillumination, when occasioned by unilateral suppuration. The diseased side showed a darker shadow than the other as soon as the suppurating cavity was washed out, it showed lighter than the other. In order to satisfy himself that pus throws a shadow on the screen he held two reagent glasses, one filled with pus and the other with water between the screen and the source of light. The glass filled with pus gave an intensely darker shadow than the other. But Scheier believes on account of asymmetry of the skull formation and different thicknesses of the walls no definite conclusions can be reached. He could also prove the presence of foreign bodies in the nose and tonsils. Scheier recommends the procedure in children if suspicion of foreign body, as examination of the nose and larynx is difficult. The time of exposure for a head picture is from ten to fifteen minutes. With the improvements in the technic he succeeded by transillumination in utilizing the physiological understanding of the voice and speech. He especially studied on the screen the movement of the soft palate in vowel formation, the shape of the oral cavity, the tongue and the position of the epiglottis, larynx and hyoid bone in different sounds.

In increasing practical importance the Roentgen examination and photography has developed in diseases of the accessory nasal cavities. Moritz Schmidt and Spiers advocate the perforation of frontal sinus from the nose under control of Roentgen transillumination, a procedure which on account of its danger has not found much favor Winkler on account of accidental exposure of the dura instead of a supposed diseased frontal sinus, was drawn to the Roentgen procedure. He systematically studied the position of the accessory cavities in the skeleton by means of profile pictures. He also recommends the procedure on the living sphenoid bone operations, in order to ascertain the situation and depth of the cavity. Without regard to the kind of disease he believes the anatomic relation as found in profile exposures in interference on the frontal sinus, indicates the plan of operation. The Roentgen picture gives an idea which method is to be preferred in the bone operation, and also as to size of flap in osteoplastic procedures. From the picture we can recognize the height of the frontal sinus, thickness of the anterior wall and the relation of the ethmoidal cells to the frontal sinus.

Goldmann at the instigation of Haegler, and in contrast to Winkler, took pictures of the skull in the occipito-frontal diameter and recommended this method of transillumination to demonstrate the sinus. By this method it is proven whether the patient has a frontal sinus, if both sinuses are equally or unequally developed, if they are partly or wholly separated by a septum, if bony lamallae partly or wholly separate individual sections. In fact the operator derives knowledge of a number of individualities of the frontal sinus which before the operation are of great value to him. The previously attempted efforts to determine the deep diameter of the frontal sinus by mean of Roentgen pictures have not succeeded. In taking pictures in the bitemporal diameter the accessory cavities cover one another, showing an indistinct, scarcely recognizable picture.

Goldmann and Killian have recently reported the results of their joint work. In conformity with the results of Goldmann the continuation of the experiments have shown that the Roentgen pictures are of especial diagnostic value when taken in the sagittal diameter of the skull, giving information of the topographic anatomic relations of the accessory cavities and their diseases. It should be classed with the other methods of examination as of equal value, and serves to complete the same, without however making them indispensable. A resumé of thirty observations furnish evidence of the diagnostic value, there were cases of frontal sinus, ethmoid and antrum suppuration, disease of all the sinuses and one case of absence of the frontal sinus. In the reproductions of the exposures one mainly recognizes in an instructive manner the different relations of the frontal sinus to its orbital, temporal and frontal fossa, which are sometimes

separated from the main sinus by dividing walls.

Without knowledge of Goldmann's demonstrations, the author in the last few years has taken pictures of all patients suffering from accessory sinus suppurations, or that suspicioned such an affection. These exposures were made according to Grashey's method in the occipito-frontal diameter of the skull, and he was surprised, in contrast to others, to find such splendid pictures, that gave one an oversight not only of the accessory cavities, but also answered the question as to which cavity was affected. It is not necessary to mention what an advance this is over the former method, seldom or slowly leading to a diagnosis. I simply call attention to the diagnostic difficulties in antrum suppuration when we deal with a closed antrum or a frontal sinus disease when changes are absent in the middle nasal canal, or a narrowing of the same prevents an inspection with probe or canula. We can recognize by the opacity of the plate, suppurations and pathological changes of the frontal sinus antrum of Highmore and ethmoidal cells. Only the sphenoidal sinus cannot be reproduced in this manner. Under my observation the interpretation of the Roentgen plates has never lead to errors. Especial value is placed on the diagnosis of ethmoidal suppuration made by aid of Roentgen's method. For it is generally known that with a frontal sinus affection a disease of the ethmoid, or at least the frontal cells is combined, the pictures showed important points of a clinically latent disease of the ethmoid in a suppuration of the antrum of Highmore.

He also observed clinically indistinct pictures of suppuration in the median nasal cavity, in which the Roentgen plate showed isolated disease of the ethmoid without involvement of the frontal sinus. The Roentgen exposure can also, as emphasized by Winkler, especially in frontal sinus affections, influence our plan of operation. The skiagrams of former operative cases have shown that the cavities that at the time of disease showed dull pictures, in connection with other clinical symptoms of healing, cleared up again. This method is, therefore, of value in controlling results of operation.

As far as the technic is concerned, and on this the previous attempts of diagnostic value in diseases of the accessory cavities failed, an absolute fixation of the head is necessary. The patient with the face laid as near centrally on the plate as is possible lying horizontally with the abdomen on the table. Posteriorly the head is fixed with a compression bandage of Albers-Schonberg or Rosenthal. Sideways the Grashey head rests are applied. The time of exposure when using half soft tube is usually one hundred seconds.

GENITO-URINARY.

T. A. HOPKINS, M. D.

Urine Formation.—The physiologic facts, so far as known, and the theories regarding the urinary function, are critically reviewed at some length by T. Sollmann, Cleveland, Ohio (Jour.A. M.A., August 31), who summarizes his concluisons substantially as follows: 1. The modifications of Nussbaum's experiment (ligation of the renal artery to exclude the glomeruli from the circulation) prove that in the frog all the normal urinary constituents can be excreted vicariously by either glomeruli or tubules, but the elimination of water, and probably of most other ordinary constituents, occurs normally only by the glomeruli. Certain pigments, on the other hand, are excreted exclusively by the tubercles. It is probable, though not proved, that similar conditions exist in mammals. There is no conclusive evidence that urea is secreted differently from the salts. 2. As stated, the tubular epithelium can secrete all the urinary constituents in the frog. It is highly probable that it secretes pigments in mammals. It is proved that it secretes sugar under the influence of phloridzin, and doubtless can secrete other substances, but there is no definite evidence that it normally secretes any of the normal constituents. Reabsroption under normal conditions is neither proved nor disproved; its acceptance, however, explains many phenomena. If it occurs it must be selective. 3. Filtration through the glomeruli is physically possible, as it occurs in dead kidneys The effects, moreover, of saline diuretics correspond closely in both living and dead kidneys, indicating that filtration is an important factor in urine formation, though there is no direct proof. Filtration, however, can not explain the composition of the urine. 4. It is probable, however, though not proved, that glomerular urine may, at times, have a much lower concentration than the plasma. The formation of such a fluid would probably require more than the ordinary filtration pressure— in other words, would be a secretory process. 5. It is probable also, though not proved, that the urine ordinarily becomes more concentrated as it passes through the tubules. In any case, the formation of a urine of greater concentration than the plasma requires an unknown force—whether secretory or absorbing—which must be classed as vital.

6. There is no satisfactory explanation of the adaptation of the urine to the needs of the body, none of the proposed theories resting on conclusive proof. 7. There is no binding evidence as to the mechanism of any of the diuretics, but it is highly probable that salts act mainly physically and mainly on the glomeruli, and that phloridzin acts on the tubules. The diuretic actions of water, urea and caffein are even more obscure.

Indicanuria, its Etiology and Practical Significance.—Wm. H. Porter (Med. Rec., June 15, 1907) says that indicanuria is one of the most important conditions in connection with clinical medicine. Bayer showed that a simple substance, indol, was the antecedent of the more complex indican. It is now known that indican is the result of putrefactive fermentation. While animal proteids are more likely to undergo putrefactive fermentaion, vegetable proteids are much more difficult of digestion; hence they are less economic and often detrimental to the system. Bacterial action is always required to produce putrefactive fermentation in connection with the production of indican. A sulphur atom, which is required for the formation of indoxyl potassium sulphate, from which indican is generated, comes from the proteid molecule as a result of its oxidation reduction. The primary seat of the formation of indican is the intestine, not the liver, as has been supposed. At the same time that it is produced many other toxins are formed, which are absorbed into the circulation from the alimentary tract, and excite an endless variety of symptoms by their effect on the nervous system. The conditions favoring the production of indican are errors in diet, lack of outdoor exercise, defective digestive secretions, and profound disturbances in the working of the nervous mechanism. Indican is never a normal urinary constituent, but always indicates an abnormal condition of the system, since putrefaction cannot be regarded as a normal physiological process. Successful treatment of the condition associated with indicanuria always depends on accurate apprehension of the etiological factors producing it, and the best method of removing these factors.

Serum Treatment of Gonorrhea.—Referring to their previous communications on the subject (see Journal Jan. 27, 1906), J. Rogers and C. Torrey, New York City (Jour. A. M. A., Sept. 14,) publish further results of experiments with the serum treatment of gonorrhea. The method of producing the serum is described. At first rabbits were mployed exclusively, but their serum was ound to be toxic to some individuals and the same is true of goat serum. Therefore, the serum of sheep, which was found innocuous, was used in their later experiments. The serum has always been given in small doses, viz., 2 c.c. or about 40 minims. Larger doses were not tried, as these were found sufficient. The treatment was found efficacious in some complications, but not specially so in acute urethritis, vaginitis and conjunctivitis. The complications thus amenable are classed by the authors as follows: 1. Those arising by direct extension of the primary infection into organs like the prostate, epididymis, testicle, bladder and Fallopian tubes in direct continuity with primary focus. 2. Those due to the entrance of the germ into the circulation directly or through the lymphatics, such as iritis arthritis and endocarditis. General peritonitis may be more properly included in the first class. Case reports showing the effects of the method in these various conditions are given. The authors believe that the serum causes a local disintegration of the gonococci and a liberation of endotoxins. The primary bactericidal action seems to the authors more probably due to the presence of specific immune bodies in the serum than indirectly by phagocytic action and opsonins. Experiments which will be published later indicate that immune bodies are present in abundance. It is possible however that the gonotoxin liberated in the tissues indirectly may play an important part in the curative process by causing an influx of exudate containing leucocytes and that these phagocytic cells destroy the remaining gonococci more readily through having been acted on by the serum. There is no evidence that the serum is in any sense an antitoxin.

Serum Diagnosis of Syphilis.—P. Fleischmann, Berlin, and W. J. Butler, Chicago (Jour. A. M. A., September 14), explain the principle and method of the serum diagnosis of syphilis developed by Wassermann describing in detail the technic and giving their own results with its employment. The method is based on the phenomenon of the fixation of complement first observed by Border and Gengou, and is somewhat complicated, but it demonstrates the existence of specific antibodies in probably all cases of active existing syphilitic infection, and the authors consider it of incontestable value as a diagnostic measure. In thirty-eight cases with a history of syphilis the reaction was positive in twenty-nine and inquiry revealed that the other nine patients were either under active treatment or had undergone such. In no case with active manifestations did the reaction fail, except in cases

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of tabes, in which disease it is possible that the symptoms may persist on account of irreparable injury after disappearance of the antibodies. The authors think that a positive reaction with this test may be considered a sure indication of syphilis, a point of especial importance in diseases in which the determination of their etiologic relations to syphilis is in question. The importance of the test as regards contagiousness, urgency of treatment, prognosis, etc., is not so definite, but they think they do not err in saying that the demonstration of antibodies is a tenable indication for treatment. On the other hand, one can not say at present how far we can use the disappearance of antibodies in judging a cure. During or after treatment, it is true, there is only a slight reaction or none at all, but more experience is needed before the full significance of this fact can be estimated. More study of the subject, which they think has not received as yet due consideration, is needed, and the hope of stimulating other similar investigations has been their chief incentive in this publication.

Prostatectomy by Special Technique.—Fallen Cabot (Postgraduate, Sept., 1907) advocates and employs two operations in dealing with prostatic hypertrophy, where there is much debility or other reasons militating against complete operation at one sitting. He does a primary suprapubic cystotomy, under local anesthesia if possible, from this he expects the patient to be sitting up on the second day and soon on his feet and about the house. Free drainage is maintained and the bladder irrigated with boric acid and silver nitrate solutions until the urine clears. The patient is brought to a good physical condition before undertaking enucleation, which is done under gas and chloroform anesthesia. This operation should take from seven to ten minutes. The prostatic wound is packed with gauze soaked in adrenalin solution, a catheter introduced to the gauze pack and the large drainage tube replaced. Hot saline solution should flow over the operative area throughout the operation. Under these steps there is little shock and little hemorrhage. He holds that 80 per cent of prostates are better reached through the abdominal route, that success will follow in a much greater per cent of these with the technique above than with a single operation. He holds that ether should never be used in these cases, as its irritating qualities lead to fatalities. He draws the following conclusions: 1. Never remove a prostate if there is any question of the patient's fitness to resist the shock. Do a preliminary drainage, suprapubic, and a wait developments. 2. Employ local anesthesia for the preliminary cystotomy when possible. 3. Never use ether for the prostatic enulceation. 4. Be sure the bladder is completely drained after the operation and that the patient leaves his bed in a day or two for his meals. 5. Choice of method: Perineal route in 20 per cent. Suprapubic at one sitting 40 per cent. Lilienthal's interval operation 40, per cent. 6. Perineal route suitable for simple uncomplicated small prostatic hypertrophy. 7. Suprapubic routein all severe, complicated prostatic disease, and in about one-half of these cases the two stage method of Lilienthal should be employed. 8. Cystoscopy is of some value in prostatic disease, but prolonged efforts to use it should not be employed.

MEDICO-LEGAL.

E. S. McKEE, M. D.

Judicial Crimes.—It has been frequently claimed and is probably largely true that criminal law has made no progress in two hundred years, and on this account is in no condition to be compared with medicine. When a sick man is sent to the hospital he is not sent for a term of months or years, but till he is cured. When a man is cured of a moral disease in a prison he is not let out, but is kept there and the treatment, or punishment, continued for a stated time. Even when this time has expired and he is released the public, no difference how severe his treatment or perfect his cure, continue the treatment or punishment by ostracising him more or less for the remainder of his life. True it is that a culprit is seldom cured of moral disease in a prison, yet that should be the object of his incarceration. Doctors do not say that a man with typhoid fever must go to the hospital or the bed for three years, a man with the smallpox ten years, a man with appendicitis twenty years, unless he has money, a man with a boil thirty days, and a man with a boquet of boils, a carbuncle, ninety days. The penitentiary is full of prisoners suffering quite as much from the sins of the judges who condemned them as their own. The judge has often no means of knowing the circumstances of the case that lead up to it, the annoyance, the aggravation, the suffering, and want which lead up to committing, in fact forced the deed. Had he been in the culprit's place, had his surroundings and bringing up, would he hav. done differently? He does not know whae

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hidden mental or physical defect may have preyed upon him.

A Judge's Opinion of Medical Witnesses.—Mr. Justice Brown, of the U. S. District Court, in a paper before the Rhode Island Medical Society, said that it was a common opinion among judges in his state that physicians as a rule made good witnesses, that they were honest, clear in their statement and showed a trained mind. There are, however, in the medical profession, as in the legal, a very small minority who are dishonest, and these men present a substantial problem. It is not merely a problem of the medical expert, but a problem of the liar on the witness stand The special problem of the liar who is given the privilege of expressing his opinion on the witness stand on obscure questions. The problem is practically the same in all branches of expert testimony. The dishonest medical expert must be dealt with as any other dishonest witness as an individual.

Dr. Edward R. Taylor, physician and lawyer, San Francisco, dean of Hastings Law School of the University of California, has been elected mayor of San Francisco, vice Schmitz in jail. Last arbitrary act of Schmitz was to turn out the Board of Health, because it did its duty in a position to his command in acknowledging the presence of the plague in the city and taking active measures to suppress it. We hope this medico-legal combination will prove a benefit to the stricken city.

Professional Secrecy.—Brouardel, the noted French authority on medical jurisprudence, recently deceased, was of the opinion that a physician was not justified to inform a father whose daughter was about to wed, of the syphilitic condition of the prospective groom. Vibert, another French authority of equal prominence, is of the opinion and cites a decree of the court of Dijon that a physician who should fail to inform a wet nurse that the child which was put to her breast was infected with syphilis would not only be guilty of a base act, but also liable for damages should the disease be communicated. This same latter writer expresses an opinion that a physician who should report a servant's infected condition to an employer should be liable for damages for breach of his duty. Another matter which has puzzled the French writers somewhat is whether or not the birth of a child to an unmarried woman should be reported or not. In one case which they brought up in court for elucidation it was held sufficient to report the fact of the birth having taken place without revealing the name of the mother. The writer of this article trembles to think what would happen to him were he to report full facts in regard to the births of children to unmarried women (and married men). It seems that this would be a good solution of the is question. Report the birth of an illegitimate child, but not the name of the parent or parents. The reported birth rate would then probably increase. The statute is meant to be used as a shield for the patient not a weapon of defence for the wrong doer—the physician. A murderer who defends on the ground of insanity may not be called against him. It has been decided however, that the physician of the victim can be called and that the slayer can not exclude the testimony by invoking the victim's privilege. The acme of absurdity was reached in the Depositer case, in which the defendant charged with criminal assault on a little child, sought to exclude the testimony of the physician examining her. It would seem clear that a man who for the sake of winning a lawsuit in which damages are claimed puts at issue his bodily condition making it, indeed, the measure of his damages, the defendant and the court, should be entitled to know all about that condition, its causes and extent and to that end should be allowed to call his physician; this the law forbids unless the physician be unlicensed, in which event the sacredness of his privilege disappears. One of the injustices resulting from legislation on this subject is that of insurance cases. For instance, a man secures insurance on his life, answering in the negative the question, "Did any of your relatives die of consumption?" He dies and payment is refused on the ground that his father died of consumption. Suit is brought and the company calls the physician who attended the father, but his testimony is excluded though he is called on to betray no secret, the cause of death being on record at the health office. The reason of the privilege no longer exists, and upon the familiar principle that where the reason of the rule fails the rule ceases to exist; it would seem that the physician ought to be allowed to testify to the fact already published to the world. Sir Caesar Hawkins' reply to the House of Lords at the trial of the Duchess of Kingston was, "I do not know how far anything which has come before me in a confidential trust in my profession should be disclosed consistent with my professional honor," was very good indeed.

An easy way to straighten out a probe that has been much bent and twisted is to roll it under the foot on an even floor.

SOCIETY PROCEEDINGS

MEDICAL ASSOCIATION OF THE SOUTHWEST.

The annual meeting of this association will be held in Hot Springs, Ark., on October 8, 9, 10, under the presidency of Dr. C. M. Rosser, of Texas. Elaborate provisions for entertainment are being made by the profession of Hot Springs, under the chairmanship of Dr. Thos. E. Holland. The sessions will be held in the Eastman Hotel, in three sections. The following is the preliminary program:

DR. C. M. ROSSER
President Medical Association of the Southwest.

SURGICAL SECTION.

Chairman, Dr. Jabez N. Jackson, Kansas City, Mo.

Vice-chairman, Dr. A. L. Blesh, Guthrie, Okla.

Secretary, Dr. B. F. Fortner, Springfield, Mo.

Jabez N. Jackson, Kansas City, Mo,. Chairman's Address.

C. R. Shinault, Little Rock, Ark., Drainage in Surgery.

C. E. Bentley, Little Rock, Ark., title to be announced.

Joseph P. Runyan, Little Rock, Ark., title to be announced.

William E. Laws, Hot Springs, Ark., Diagnosis and Surgical Treatment of Some of the Non-tubercular Diseases of the Knee Joint.

St. Cloud Cooper, Ft. Smith, Ark., Intussusception.

J. E. Gilcreest, Gainesville, Texas, The Treatment of Wounds.

A. C. Scott, Temple, Tex., Abdominal and Pelvic Drainage.

Bacon Saunders, Ft. Worth, Tex., Malignant Disease of the Mammary Gland, their Diagnosis, Prognosis and Treatment.

G. B. Foscue. Waco, Tex., title to be announced.

Joe Becton, Greenville, Texas, title to be announced.

J. D. Griffith, Kansas City, Mo., Anatomy of the Lymphatics and Phlegmon of the Abdominal Wall.

Willard Bartlett, St. Louis, Mo., The Value of the Metal Pin for Fractured Long Bones, with a report of nine cases.

Charles H. Wallace, St. Joseph, Mo., title to be announced.

Frank J. Lutz, St. Louis, Mo., Empyema and its Treatment.

Walter B. Dorsett, St. Louis, Mo., title to be announced.

John Young Brown, St. Louis, Mo., title to be announced.

Howard Hill, Kansas City, Mo., Restoration of the Pelvic Floor.

Robert McD. Schauffler, Kansas City, Mo., Lesions of the Sacro-iliac Joint.

Chas. E. Bowers, Wichita, Kas., Prostatic Hypertrophy in the Aged Male. Absract Etiology. Differential anatomy. Report of operative cases.

George M. Gray, Kansas City, Kas., title to be announced.

F. H. Clark, El Reno, Okla., Surgical Affections of the Kidneys.

A. L. Blesh, Guthrie, Okla., The Surgical Consideration of Congenital, Oral and Labial Clefts.

D. A. Myres, Lawton, Okla., title to be announced.

Fred. S. Clinton, Tulsa, I. T., title to be announced.

LeRoy Long, South McAlester, I. T., title to be announced.

A. E. Hertzler, Halstead, Kas., Diagnoiss and Treatment of Lung Abscess.

SECTION ON EYE, EAR, NOSE AND THROAT.

Chairman E. H. Carey, Dallas, Tex.

Vice-chairman, H. Moulton, Ft. Smith, Ark.

Secretary, J. F. Sell, Wichita, Kas.

Edward H. Carey, Dallas, Texas, Chairman's Address.

H. Moulton, Fort Smith, Ark., Operation for Chronic Suppuration of the Frontal Sinus.

R. S. Magee, Topeka, Kas., Management of Corneal Injuries.

Frank Boyd, Ft. Worth, Texas, Tonsillectomy and Its Necessity.

R. H. T. Mann, Texarkana, Ark., The Submucus Window Resection of the Cartilaginous Septum.

L. Haynes Buxton, Oklahoma City, Okla., Optic Atrophy: (1) Etiology; (2) Pathology; (3) Differential Diagnosis and Treatment.

Election of Officers.

G. J. Dorsey, Wichita, Kans., Glaucoma.

J. E. Sawtell, Kansas City, Kas., Ethmoidal Sinus Affections.

P. P. Fulkerson, St. Joseph, Mo., Trachoma.

Dr. Camp, Springfield, Mo., paper.

Zuber N. Short, Hot Springs, Ark., paper.

Turner Robert, Paris, Texas, The Comparative Value of Chemical and Electrical Cauterization in Hypertrophic Conditions of the Nose.

George W. Moser, Parsons, Kans., Surgical Treatment of Detached Retina and Report of Several Cases.

SECTION ON GENERAL MEDICINE.

Chairman, S. C. James, Kanass City, Mo.

Vice-chairman, F. B. Young, Springdale, Ark.

Secretary, C. C. Goddard, Leavenworth, Kas.

Howard Hill, Kansas City, Mo., Gastric Ulcer.

Flavel B. Tiffany, Kansas City, Mo., An illustrated lecture on some of the more common diseases of the eye.

F. B. Young, Springdale, Ark., Polycystic Degeneration of the Kidneys, with report of a case.

Edwin B. Kenner, Galveston, Tex., A Piece of Chewing Gum as a Nucleus for a Vesical Calculi.

L. O. Green, Pea Ridge., Ark., Gastro-Enteric Intoxication.

S. S. Glasscock, Kansas City, Kan., Divorces.

T. E. Potter, St. Joseph, Mo., Cholecystitis.

J. M. Taylor, Ft. Smith, Ark., Tuberculosis of the Kidney.

W. H. Stauffer, St. Louis, Mo., Sigmoiditis.

John Punton, Kansas City, Mo., The Failure of Law and Lawyers to Cope with Modern Medico-legal Exigencies and its Remedy.

Jerome D. Potts, St. Louis, Mo., Rectal Diseases as Considered by the General Practitioner.

A. K. West, Oklahoma City, Okla., The General Practitioner and the Specialist: The Sphere of each and their Relationship.

B. F. Collins, Needmore, I. T., Hysteria.

B. L. Hale, Neal, Kas., Toxemia of Pregnancy.

J. W. Duke, Guthrie, Okla., Periodical Insanity.

Thos. J. Beatty, Kansas City, Mo., Disturbances of Various Kinds Coincident with the Menopause.

R. D. Moore, Omaha, Tex., Puerperal Eclampsia.

W. R. Russell, Texhoma, Okla., Management of Pregnancy.

J. Robt, Buchanan, Nevada, Mo., A Plea for Greater Accuracy in our Therapeutics.

N. H. Grady, Monett, Ark., Pneumonia; its Causation and Treatment.

W. C. Bradford, Shawnee, Okla., Tuberculosis.

C. S. Kenney, Norcatur, Kas., Cholera Infantum.

Wm Frick, Kansas City, Mo., Ringworm.

F. W. Shelton, Independence, Kas., Medical Treatment in Surgical Diseases.

A. B. Leeds, Chickasha, I. T., Some Observations on the Modern Treatment of Disease.

J. H. Moody, San Antonio, Tex., Why So Many Cases of Drug and Alcohol Addiction Recur After Treatment.

GENERAL EVENING SESSION.

Wm. G. Moore, St. Louis, Mo., Address: "Above all, the Clinician."

MEDICAL SOCIETY OF THE MISSOURI VALLEY.

An enthusiastic meeting of this association was held in Council Bluffs, on September 5 and 6, where an excellent program of fifteen papers was disposed of. The discussions were enjoyed by those in attendance. Resolutions were adopted deploring the death of Dr. Donald Macrae, father of the society, and its first president; and Dr. T. B. Lacey, one of the charter members, and for many years treasurer of the society.

The society placed itself on record as favoring a National Board of Public Health, with a medical man in the President's Cabinet.

The election of officers resulted as follows: President, Dr. W. F. Milroy, Omaha; first vice-president, Dr. C. B. Hardin, Kansas City; second vice-president, Dr. A. E. King, Blockton, Iowa; treasurer, Dr. H. B. Jennings, Council Bluffs; secretary, Dr. Chas. Wood Fassett, St. Joseph, Mo.

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Contributions and books for review should be addressed to the Managing Editor, 319 and 320 Century Building, St. Louis, Mo.

MEDICAL MISCELLANY

A FEMALE STATE BACTERIOLOGIST FOR WASHINGTON.—At its August meeting the State Board of Health appointed Dr. Rose Bebb state bacteriologist and located the laboratory in Seattle. At its last session the legislature appropriated $3,000 to maintain the laboratory for two years, which sum is now available. Dr. Bebb graduated from the medical department of the University of Minnesota in 1897. She made a special study of bacteriology in New York, where she was connected with the Board of Health. She came to Washington for Board of Health work at North Yakima and for the year has acted as bacteriologist for the city of Tacoma.

CARE OF THE TEETH BY AFRICANS.—The Meunchener Medizinische Wochenschrift comments on the wonderful appearance of the teeth of the African negroes, which has been often ascribed to purely climatic conditions, and to the food they eat. It seems not to have been suspected that these ignorant antives might have remedies for the treatment of the diseases of the teeth, or that they should take special care of their teeth. From the many observations made by the German governors of the Imperial Government's colonies, it appears that the natives are even more careful of the teeth than are most Europeans. The sound teeth of ivory whiteness can no longer be said to be the result of Providence, but of purely prophylactic agencies applied in an empirical manner, and we must say, with great success. Many herbs, barks and juices are made use of by the Africans in the treatment of their teeth, if the reports of the German governors are correct. A few instances may be cited. In Ngumba, when the teething period is over, an infusion made from the leaves of the sson tree is held in the mouth. This is said to fasten the teeth, though it may simply shrink the gums on account of some styptic agency contained in the leaves. To relieve toothache, the natives living near the source of the Nile use the roots of the leguminous plant, Dalbergia melanoxylon. The A-Madi, A-Mangbattus, and A-Mangalbles, living to the westward of the Nile's source, prepare an infusion from the seeds of a climbing vine known as the a'Kadesso or Kasso, which is said to be a specific for toothache. It seems too remarkable to be true that this same decoction is used in the preparation of an arrow poison, and, in times of famine, as a food, and yet the educated gentlemen governing in Africa have personally made these observations. For a toothbrush they make use of the wood of the madi cratlava Adansonii and also of the kitsch salvadora persica. Whether these woods have inherent properties which are peculiarly beneficial to the teeth is still a mooted question, though the white teeth to the natives proclaim its usefulness as a toothbrush. The Wangamwasi of German East Africa are reported to color their teeth with the juice of the fruits called mena. While the use of the above agents may be attributed to some form of fetish worship, still this is no reason why we should condemn them as remedial agents a priori. It must not be overlooked that many of the fetish priests are more learned in the wisdom of the woods than their neighbors. That they should symbolize that which they wish to communicate to their people, holding up a fetish, adds to, rather than detracts from, their knowledge of the whims of a naturally superstititous people. The medicine man of our Indians has enriched our pharmacopeia with many curative drugs; we must expect the same from these medicine men of Africa. National Druggist.

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For Sale.—Western X-ray coil and appliances. Complete outfit for X-ray work in perfect condition. Will make a low price to cash purchaser. Address the Editor of the Fortnightly.

Meatox is a concentrated nitrogenous food made of pure lean beef. It is absolutely free from preservatives, and it keeps indefinitely even in unsealed containers. Meatox is different from the so-called Meat Juices or Meat Extracts in that it contains all the nutritive elements of beef,—namely, assimilable proteids, which are the nutrients, whereas the Meat Extracts merely represent the stimulant parts of beef Meatox is of pale yellow color, possessing a faint odor of meat and an agreeable flavor imparted by celery seed. In this respect it is superior to the Extracts of Beef. which possess a strong and peculiar odor and, being merely stimulants, do not contain the nourishing elements the patient's case requires. Meatox, contains from 73 to 75 per cent. of proteid matter which is readily assimilable. Good lean beef contains from 16 to 20 per cent of proteids; Meatox on the other hand contains from 73 to 75 per cent of proteids; one pound of Meatox contains the nutritive substances (proteids) of from 4 to 5 pounds of lean boneless beef or about 10 pounds of ordinary butcher's meat with the bones and fat. The presence of this high percentage of proteid matter commands the use of Meatox as a dietary necessity to the discriminating physician Meatox can be eaten mixed with cereals or vegetables, milk broth, etc. Almost every form of food can be prepared with Meatox. It should be prepared at a temperature not exceeding 120°F to avoid cooking it. Soldiers or sailors in service can be fed with 3 ounces of Meatox per diem in connection with cereals, cooked green vegetables, etc. In all cases the best results will be obtained if Meatox is taken in its original condition after which the patient should drink some water or milk to wash it down. A few trials will convince discriminating physicians that Meatox will be tolerated by most dyspeptic patients, when taken in its original granulated form, ½ ounce every five hours (5 teaspoonfuls of Meatox represent 1 ounce by weight). No less can be said in favor of Meatox when employed in the treatment of diabetic patients. Here the patient needs a large amount of proteid matter to repair the waste of economy and without overtaxing their patient's stomach. 3 ounces of Meatox per diem will supply him with all the nourishing quality of meat. This fact of its being borne and assimilated by delicate stomachs is of the utmost importance, Physicians during the summer vacations will find Meatox the best addition to their outfit. It can be eaten on buttered bread or toast presenting a veritable multum in parvo of nourishment.

Gastro-Intestinal Ailments of Young Children.—(By H. B. Brown, M. D., Waukegan, Ill., Medical Summary, July, 1907.)—As the hot weather approaches the usual number of cases of gastro-intestinal ailments will confront us and if we be not alert the same mortality of old will occur among our little patients of one and two years. The keynote to success in the management of these cases is to see that correct feeding is enforced and to keep the alimentary canal as clean and nearly aseptic as is possible. If this be done much suffering can be obviated, and many little lives saved. Every medical man these days is capable of giving correct advice on infant feeding, the care of bottles, accessories, etc., if he will only take the time and trouble to make the mother understand how important it all is. The doctor's suggestions on this matter are too often regarded as simply platitudes and not thought of seriously until the child is in the throes of a severe illness. The following clinical reports are illustrative of my usual method of handling the more common, but serious, gastro-intestinal diseases we meet during the heated season: Ethel G., aged ten months, suffering from cholera infantum—bottle fed. Was passing watery stools every few minutes. Temperature had been considerably elevated, but was now slightly abnormal. Mouth and tongue parched. Considerable emaciation and a scaphoid abdomen. Circulation weak and respirations labored. In fact an extreme prostrate condition. Treatment.—I put four ounces of glyco-thymoline with eight ounces of water and gave it as a high enema, causing it to be retained as long as possible. This was repeated every hour or so until the bowels were thoroughly cleansed and the stools diminishing in number. Gave one-tenth grain of calomel every two hours until the discharges showed the characteristic greenish color. Also gave the following:

℞ Elixir lactopeptine..... ℥ij
Glyco-Thymoline ..... ℥ij
Oil peppermint..... gtt. j

M. Sig.: Twenty drops every hour. After eight hours the child was able to take nourishment and retain it. This consisted of cold pasteurized milk diluted with equal parts of lime water. Child was given all the cold water and lemonade she wanted. She made a good recovery.

Pneumonia-Bronchial and Croupous

SUCCESS ATTENDS THE USE OF FITCHMUL

by thousands of physicians because its components meet all the indications for treatment in these diseases.

¶ The less severe cases yield to its influence from the outset—the more severe, as soon as resolution begins.

¶ It would be difficult, indeed, for the most rationalistic of physicians to suggest any superior combination, or one more exactly fitted to the indications, to wit:

¶ BALSAMICS as antiseptics;

¶ CHLORIC ETHER to stimulate heart and respiratory centers and tone circulation;

¶ HYDROCYANIC ACID to allay irritation of lungs and major bronchi;

¶ TARTRATE OF ANTIMONY to thin secretions—loosen them and stimulate expectoration, and

¶ AROMATICS to soothe the stomach.

* * *

¶ A FITCHMUL EPITOME of Constitution and Capacity.

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Recent Clinical Reports and Physicians' Samples Free

THE FITCHMUL COMPANY, Concord, N.H.

Anatomik Footwear—We take pleasure in calling the attention of our readers to the important announcement on page 58. this issue. Dr. Cole, the inventor of Anatomik footwear, has applied the plumb and level of the architect and builder to the shoe question, so that in brief, anatomik footwear means rational shoes for children and adults, perfectly distributing the body weight, thus preventing and relieving flat foot and all strains, obviating the use of supports of any kind. Anatomik shoes relieve the aches, pains swellings and cramps in the feet and legs experienced by most letter-carriers, policemen, nurses, clerks, waiters, heavy people and all those who are on their feet constantly. All children should wear anatomik shoes from infancy. This firm also makes for cripples special shoes which are better than braces. Read the essays by Cole: "Malformations of the Feet, a New Method of Treatment" and "Shoes as a Cause of and Cure for Deformity," sent free on request to any physician.

Quantity of Lithium in Natural Mineral Waters Deficient.—Lithium is a constituent of many mineral waters, and to it many celebrated springs owe their world wide reputation: and herein is discovered their heralded pre-eminence in affording relief to those afflicted with calculi or gravel, and rheumatism or gout. The deficiency of the waters lies in the proportion of salts that are actual uric acid solvents—a proportion that is altogether too minute to be of more than relative utility. By commingling lithia and sodium phosphate in proper proportions with certain of the "bitter water" salts, as represented by sal hepatica, a compound is secured that is superlatively more active than either the lithia or sodium salt alone, or, indeed, than any natural mineral water. Recognizing this, the most eminent practitioners latterly have taken to prescribing sal hepatica in preference to the natural waters, with the result that the remedial action of the latter is enhanced, the untoward manifestations accruing reduced to a minimum and their palatability materially increased.

Abbott's Saline Laxative.—It is universally admitted to be desirable to accomplish any necessary therapeutic indication with the smallest necessary quantity of medicine and the least possible interference with the functions of the body. Since we must help, let us give absolutely not a hair's breadth more assistance than is requisite, since further aid ruins self-dependence, both moral and physical. For this reason Abbott's saline laxative is superior to the crude salts and saline waters, because when administered in this form the dose is but a small fraction of that required of the raw salts. Saline laxative also has the unique distinction of being the only saline in the market which, when taken on rising, acts just after breakfast, once only, without a particle of irritation or griping, and then stops for the day. Other salines and especially the crude purgative waters will often continue acting at intervals all day long, to the intense discomfort of the victim. The same (efficient) dose of Abbott's saline laxative may be continued, if necessary, for years, without needing to increase it. It is obtainable either on prescription at all leading pharmacies or direct from the laboratories of The Abbott Alkaloidal Company, Chicago.

MINE ENEMY.

He smiled beneath the thing which made me quail,
And bore him bravely on that blighting day.
God made my enemy to me a light;
For he could bear, while I had heart to fail.
How can I falter in the weary way.
Knowing mine enemy would walk upright?
—Annie Pike Greenwood in September Century.

DEATH DEFIED.

There dwells one bright Immortal on the earth,
Not known of all men. They who know her not
Go hence forgotten from the House of Life,
Sons of oblivion.
To her once came
That awful Shape which all men hold in dread,
And she with steadfast eyes regarded him,
With heavenly eyes half sorrowful, and then
Smiled, and passed by. "And who art thou," he cried
That lookest on me and are not appalled,
That seem'st so fragile, yet defiest Death?
Not thus do mortals face me! What art thou?"

But she no answer made: silent she stood;
Awhile in holy meditation stood,
And then moved on thro' the enamored air,
Silent, with luminous uplifted brows—
Time's sister, Daughter of Eternity,
Death's deathless enemy, whom men name Love.
—Thomas Bailey Aldrich, in The Century.